CLINICAL SUPERVISION: COMBATTING ATTRITION IN THE HUMAN SERVICES FIELD

by

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PROJECT SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF EDUCATION
IN
COUNSELLING

UNIVERSITY OF NORTHERN BRITISH COLUMBIA

April 2019

Abstract

Clinical supervision has been identified as a key component in combatting attrition in the human services field. Unfortunately, clinical supervision is not utilized in its full breadth, leaving workers to continuously suffer the consequences of cumulative stress from their complex work. This project is a result of a review of the literature on clinical supervision. The literature has indicated that clinical supervision is an essential tool for supporting workers to manage the emotional and psychological workplace hazards that they frequently encounter. The literature has identified three functions of clinical supervision and highlights that the administrative function is the one most often used. However, there are two other's-support and education/mentoring that supervisor's need to be aware of and integrate into their supervision practices.

This project will assist supervisors to round out their supervision practices. It will accomplish this by producing a guidebook that instructs how to conduct clinical supervision- beyond the administrative function that most supervisors are likely familiar with. The guidebook explicitly identifies why clinical supervision is important and then explores the support and education/mentoring functions in detail.

Acknowledgement

First and foremost, I would like to thank my husband Loyd for his unwavering support throughout my entire education journey. You have taken on so much, providing me the time and space I have needed, semester after semester, for reading, writing and reflecting…for over three years! When I have been overwhelmed and on the verge of quitting, you have comforted me and encouraged me to keep pushing forward.

Next, I would like to thank my closest friends, you know who you are. You have also encouraged me to keep moving forward. At times, you have also provided some much needed distraction, getting me out of the house and into the fresh air to ground me in the small joys-sunshine, dog walks, companionship and laughter.

Lastly, I would like to thank Dr. Linda O'Neill. I am grateful for the opportunity to learn from you. You have challenged me to grow both as a professional and as a human being. Your passion for the profession is inspiring and although I am excited to move on to the next chapter of my life, I will miss sharing time and space with you.

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Chapter One: Introduction

Clinical supervision is the key to minimizing the negative effects that a worker in the human services field experiences in the conduct of their day to day work. The cumulative effects of worker's bearing witness to others' suffering can be profound, leading to a variety of difficulties (Berzoff & Kita, 2010). Clinical supervision is a tool that enables supervisors to work with supervisees in a focused manner to assess not only workplace performance, but more importantly, worker's needs with respect to support, mentoring and education (Lietz, 2018). The application of clinical supervision can take many forms, ranging from informal conversations wherein the supervisor is providing general guidance and mentorship to formal supervision that includes clear supervisee outcomes with affiliated tasks to achieve identified outcomes.

The foundation of the clinical supervision process is the relationship that the supervisor can establish with the worker, also known as the supervisory working alliance (Kim & Lee, 2009; Sprang, Craig, & Clark, 2011; Strickler, Valenti, & Mihalo, 2018; Tsong & Goodyear, 2014; Williams & Clemens, 2012). A strong supervisory working alliance relies on the ability of the supervisor to create a supervisory atmosphere that is empathic, transparent, supportive and collaborative (Borders, 2014; Cheon, Blumer, Shih, Murphy, & Sato, 2009).

The genesis of this project was a thematic review of the literature on compassion fatigue, identifying the protective factors. What the literature revealed, time and again, was that clinical supervision was a fundamental protective factor against compassion fatigue. This led to an examination of the components of clinical supervision. The literature identified the supervisory working alliance as the critical feature that enabled the implementation of the full scope of clinical supervision.

The result has been the formulation of a clinical supervision guidebook that supervisors can incorporate into their current practices to enhance those practices.

Significance of the Project

Due to the very nature of the work, practitioners in the human services field are continuously exposed to stressful situations. The clients that they serve oftentimes have experienced trauma and practitioners bear witness to their stories. In particular, within child welfare settings, practitioners not only hear client's stories, they also read explicit details about traumatic events. Child welfare workers are the first responders to reports of child abuse and neglect. District offices are not always staffed sufficiently, leaving workers with little time to adequately process all of the information, and the associated feelings, that their cases present. The result of witnessing ongoing traumatic events and hearing traumatic stories can be the practitioner experiencing a variety of negative reactions.

Cumulative stress reactions that workers are vulnerable to include burnout, vicarious trauma, secondary traumatic stress and compassion fatigue. While oftentimes these terms are used interchangeably, there are some stark differences between them.

Burnout is an accumulation of unresolved work stress. The stress load increase is gradual and over time can become unbearable. The result is worker burnout, leaving the practitioner feeling exhausted (physically, emotionally and mentally), becoming cynical in their work and experiencing feelings of incompetence (Anderson, 2000; Kim & Lee, 2009; Perry, 2014).

Unlike burnout, secondary traumatic stress, also known as compassion fatigue, is not an accumulation of stressful incidents. Secondary traumatic stress can occur from exposure to a single, traumatic event (Perry, 2014; Williams, Helm & Clemens, 2012). It is a stress response to

witnessing another person's trauma, either directly or indirectly. Practitioners in the human services field are particularly vulnerable to secondary traumatic stress. Worker's in this field are oftentimes the first responders to extremely traumatic events (i.e. domestic violence and child abuse). They are also the support people working with children and families to gather information and bear witness to graphic recounts of traumatic experiences. The consequence can be secondary traumatic stress, the symptoms of which are similar to post traumatic stress disorder (Joubert, Hocking & Hampson, 2013; Perry, 2014; Sprang et al., 2011).

Vicarious trauma is often used interchangeably with secondary traumatic stress. However, there is a very stark difference between the two, while secondary traumatic stress is experienced as trauma within the practitioner as a result of being exposed to someone else's trauma, that includes physiological and emotional reactions, vicarious trauma is a cognitive construct. Vicarious trauma can impact the practitioner's worldview, including the views they hold of themselves, their client's and society as a whole (Jenkins & Baird, 2002).

Any of the above discussed phenomena are risks for practitioners in the human services field. When left unaddressed, they can result in an early exit from the field. The trauma and complexity of the work will not diminish; clinical supervision has been identified as the key to worker health and retention.

Background of the Project

I have worked in the human services field for over fifteen years, in a variety of roles with differing levels of responsibility. There have been many overwhelming and distressing moments that challenged me to adapt strategies to protect myself from being swallowed up in other people's grief and trauma. Oftentimes, it was a journey that I felt I walked alone. Go to work,

come home raw, try to let it go, repeat. Day in and day out, that was the rhythm of my work. Unbeknownst to me, I was journeying down a path of avoidance, isolation, and apathy.

For a brief period in 2015 I received weekly clinical supervision. Initially, I was unsure what the process would feel like or how it would help my practice. Without any prior experiences with clinical supervision, I was skeptical that the supervisor, who had not worked in my specific line of work, would be able to do any meaningful work with me. Reflecting back on that time, I now recognize that my only supervision experiences had been regarding the administrative functions of my work-case consultations and workload issues. I was unaware that there were other dimensions that would profoundly impact my work. The clinical supervisor challenged me to view cases in new ways and to consider not only how clients were impacting me, but how I was impacting them. We spent virtually no time on case details, focusing instead on countertransference and ethics, enabling us to work on identifying my triggers and defense mechanisms, all of which clearly impacted my client interactions and case decisions. It was like I had been practicing in a dark room and clinical supervision switched the lights on…it was a powerful time in my practice! It assisted me in understanding how I came to case decisions and once I understood that, I was then able to link it with my profession's code of ethics. It challenged me to do a lot of self-reflection. Why was I reacting certain ways with clients? How was that impacting the course of the case and my decision making within it? What was my own personal stuff and what was the client's and how do I not take on the client's stuff?

The supervisory working alliance developed and grew quite strong, facilitating an atmosphere to enhance my skills. My supervisor and I collaborated to identify areas of practice to strengthen and worked together to identify what I could do to achieve my goals. The trust within the relationship helped to identify blind spots and plans to address them as they arose.

One such plan was to acknowledge that I needed additional support, beyond what was appropriate within the clinical supervision setting. There was no shame regarding this discovery, my supervisor had professional boundaries and conducted themselves in a highly ethical manner. I was supported to make a plan regarding the steps I would take outside of work and experienced compassion and non-judgement throughout the interaction.

In 2015, I also started graduate school part time. Each course has challenged me to look at myself in the context of relationships. As I near the end of the program, I again have the opportunity for clinical supervision, I am re-experiencing the power of the relationship and how it facilitates sound practice. It is integral to my continued development both professionally and personally.

Although I have had positive and powerful experiences with clinical supervision, I have only had clinical supervision for approximately 12 months out of the 185 months that I have been in this field. Of those approximately 12 months, only 3 months were in my paid work, the rest were through my graduate studies. I was curious to understand what the barriers to clinical supervision were. This project was borne out of that curiosity and resulted in the development of a supervision guidebook. The guidebook assists supervisors to understand why clinical supervision is important and identifies critical components to clinical supervision in order for supervisors to start developing their own supervision style.

Overview of the Project

This project explores clinical supervision and how it can not only enhance practitioner competence but also buffer against compassion fatigue and practitioner burnout. The result of the analysis is the formulation of a clinical supervision guidebook. The guidebook is designed to provide an overview of the value of clinical supervision, including impacts on workers when

supervision is not available. It then goes on to outline a framework for supervision practice, including organizational support and the supervisory working alliance.

Chapter one provides the reader with background and information regarding why this topic is important and how the writer is personally located within the subject. It provides context for the chapters that follow.

Chapter two is a thematic review of the literature on clinical supervision. The literature identifies clinical supervision as an essential component to managing compassion fatigue and countertransference among workers. It also highlights that the supervisory working alliance is the foundation that good clinical supervision is built upon. These topics are explored at length within chapter two.

Chapter three outlines the project plan and sets the stage for the final chapter- the clinical supervision guidebook.

Chapter Two: Review of the Literature

Review Methods

The review of the literature was conducted primarily using online research platforms that included EBSCOhost, Google Scholar, Academic Search Complete and CINAHL Complete. Textbooks from recommended readings for several graduate counselling classes were also used as sources. The search terms used were compassion fatigue, supervisory working alliance, clinical supervision, vicarious trauma, trauma informed supervision, secondary trauma, and burnout. Initial searches were limited to within the past ten years, however, there were several authors (Bordin, Figley, Goodyear and Sterner) that were regularly cited in multiple articles and therefore, the time frame for article inclusion was expanded to capture their work. The search results produced articles from North America, Australia, Denmark and Korea.

A thematic review of the literature was conducted, this was accomplished by broadly searching for the term's clinical supervision and trauma informed supervision. The literature identified three distinct parts to clinical supervision however, it also noted that the supervisory working alliance was the most essential ingredient to successful implementation of clinical supervision. What also emerged was why clinical supervision was so critical in the human services field. Clinical supervision was named as a protective factor against burnout and compassion fatigue, resulting in expanding the search to include those terms as well as vicarious trauma and secondary trauma. Countertransference appeared as a theme that needed to be addressed because the literature consistently defined compassion fatigue, burnout, vicarious trauma, and secondary trauma as very separate from countertransference. The fact that it was clearly stated as a separate entity, that required explicit definition in the literature, compelled me to include it as a separate theme in the literature review.

Compassion Fatigue

Compassion fatigue is a risk factor associated with work in the human services field that, if left unaddressed, can have a large range of negative consequences (Berzoff & Kita, 2010; Geoffrion, Morselli, & Guay, 2016; Mandell, Stalker, DeZeeuw, Frensch, & Harvey, 2012; Mena & Bailey, 2007; Merriman, 2015; Sprang, Craig, & Clark, 2011; Sterner, 2009; Williams & Clemens, 2012). "Compassion fatigue refers to the cumulative effect of working with survivors of traumatic life events, or perpetrators, as part of everyday work…compassion fatigue is therefore a reaction that emerges from the child-protection worker's overexposure to human suffering. Building up over time, the child-protection worker will feel less empathy for his clients as well as less compassion in other spheres of life" (Geoffrion et al., 2016, p. 272).

Compassion fatigue is often used interchangeably with the terms secondary stress or vicarious trauma and is sometimes mistaken for countertransference. However, several researchers contest that there are stark contrasts between the terms (Berzoff & Kita, 2010; Geoffrion et al., 2016; Merriman, 2015; Sprang et al., 2011; Williams et al., 2012). They assert that workers contending with secondary stress or vicarious trauma experience similar post-traumatic stress responses to those of their clients. Conversely, when experiencing compassion fatigue, the worker will sometimes suffer an existential crisis. The crisis causes them to question not only their professional competence but who they are as an individual in this world (Berzoff & Kita, 2010; Geoffrion et al., 2016; Merriman, 2015; Sprang et al., 2011; Williams et al., 2012). Compassion fatigue is distinct from countertransference, "therapists who experience compassion fatigue absorb the emotional weight of their clients' traumatic experiences in ways that negatively impact both their professional identities and personal lives…on the other hand, the

therapist's negative response to a client's suffering is readily recognized as countertransference" (Berzoff & Kita, 2010, p. 342).

A supervisee who is struggling with being bombarded with multiple traumatic events, over time, and without adequate support, may experience compassion fatigue. The consequences of unattended compassion fatigue are profound, impacting not only the worker but also their family, as well as the organization and its clients (Geoffrion et al., 2016; Merriman, 2015; Sprang et al., 2011; Williams et al., 2012). Symptoms of compassion fatigue may appear in a variety of domains- emotionally, behaviorally, and cognitively (Berzoff & Kita, 2010; Williams et al., 2012). Some specific symptoms of compassion fatigue that workers and supervisors need to be aware of include: difficulty sleeping, increased startle response, avoidant behavior, obtrusive thoughts/images about the client/material, difficulty separating work and personal life, diminished capacity for intimacy, loss of sense of purpose in career, loss of confidence, ineffective self-soothing behaviors, loss of hope, lower frustration tolerance, anxiety, depression, and dread of working with clients (Geoffrion et al., 2016; Merriman, 2015). Any of these signs, experienced for an extended period of time, indicate that the supervisee is likely suffering with compassion fatigue.

Working in the human services field has inherent risks of developing compassion fatigue. "Unattended compassion fatigue may lead to a plethora of undesirable outcomes (e.g. premature exit from the profession, boundary violations, ethical violations)" (Merriman, 2015, p. 370). Fortunately, there are several protective factors that can be actively pursued, including regular clinical supervision, peer support, organizational culture, and self-care (Mena & Bailey, 2007; Merriman, 2015; Sprang et al., 2011; Sterner, 2009).

Organizational culture is a strong protective factor against compassion fatigue (Mandell et al., 2012; Sprang et al., 2011; Sterner, 2009; Williams et al., 2012). Within the organization, support for both clinical supervision as well as peer supervision promotes job satisfaction which reduces the effects of compassion fatigue (Mena & Bailey, 2007; Merriman, 2015; Sprang et al., 2011). Organizations that promote work/life balance and personal wellness by default protect employees against compassion fatigue (Mandell et al., 2012; Sprang, et al., 2011; Williams et al., 2012).

Another vital protective factor, briefly mentioned above, is clinical supervision (Mandell et al., 2012; Mena & Bailey, 2007; Merriman, 2015; Sprang et al., 2011; Sterner, 2009). "The supervisor in any system is in a pivotal position to assist co-workers in preventing the development of secondary trauma" (Perry, 2014, p. 13). It is imperative for the clinical supervisor to openly discuss compassion fatigue in order to not only provide some education about the risks and symptoms but also to normalize that it exists (Berzoff & Kita, 2010; Geoffrion et al., 2016; Mandell et al., 2012; Merriman, 2015; Strickler, Valenti & Mihalo, 2018; Williams et al., 2012). This conversation should be ongoing in order to continue to normalize the concept as well as to guard against professional isolation (Berzoff & Kita, 2010; Geoffrion et al., 2016; Mandell et al., 2012; Merriman, 2015; Strickler et al., 2018; Williams et al., 2012).

Another function of clinical supervision that serves as a protective factor against compassion fatigue, is supervisors facilitating conversations about what the supervisee is doing for self-care. Within this conversation, it is important for the supervisor to take the time to work with the supervisee to define what self-care is and why it is important (Mandell et al., 2012; Merriman, 2015). Much like the conversations about compassion fatigue, self-care conversations

should be ongoing, normalizing that everyone needs to practice self-care regularly, not just when they are in crisis.

Countertransference

As previously stated, countertransference is not the same as compassion fatigue, Geoffrion et al. (2016) contrasts the two, providing more clarity regarding the striking differences:

First, compassion fatigue emerges from the experience of providing caring services to those who suffer, while countertransference arises from the intersubjective relationship between the client and the clinician unveiling the therapist's unconscious worlds and past psychic wounds. Second, compassion fatigue develops over time while countertransference is immediate and ubiquitous. Third, compassion fatigue tired the therapist by undermining his ideals and disturbing his hope and meaning resulting in emotional exhaustion, while countertransference does not necessarily fatigue the clinician. Fourth, compassion fatigue is not essential to therapeutic work where countertransference is; actually, compassion fatigue can interfere with the therapist's ability to help his client (p. 273).

It is acknowledged that countertransference is a by-product of working with people and cannot necessarily be eliminated. Clinical supervision should be utilized as a primary tool for processing supervisees countertransference reactions to clients (Berzoff & Kita, 2010; Geoffrion et al., 2016; Williams et al., 2012). This is accomplished, by the supervisor and supervisee working together to identify potential blind spots and discussing how supervisee reactions may be impacting clients (Corey, Corey, & Corey, 2014). Through the supervision process, it may be determined that the supervisee needs to seek out personal therapy to further understand how their

internal reactions may be impacting their work (Berzoff & Kita, 2010; Corey et al., 2014; Geoffrion et al., 2016; Williams et al., 2012).

Countertransference can be damaging if it is not managed (Berzoff & Kita, 2010; Corey et al., 2014; Geoffrion et al., 2016; Williams et al., 2012). Client case decisions are impacted by unacknowledged and unresolved countertransference and can lead to ethical violations. The British Columbia College of Social Workers (BCCSW) Code of Ethics state: "A social worker shall carry out professional duties and obligations with integrity and objectivity." Section 1.5 and 1.6 of the BCCSW Standards of Practice advise that "Social workers are aware of their own values, attitudes and needs and how these impact on their professional relationships with clients…Social workers distinguish their own needs and interests from those of their clients to ensure that, within professional relationships, clients' needs and interests remain paramount."

Similar to compassion fatigue, there can be symptoms of countertransference that are important to pay attention to when conducting clinical supervision. These include, but are not limited to: the supervisee losing objectivity (seeing themselves in the client or overidentifying with them), projecting on to the client traits that the supervisee despises in themselves, and the supervisee trying to win the affection of the client (Corey et al., 2014).

The concept of countertransference is important for both supervisor and supervisee to be familiar with. It is important during discussions about countertransference to normalize the concept and acknowledge and discuss how the supervisor and the supervisee can both experience it within the supervisory working alliance (Berzoff & Kita, 2010; Corey et al., 2014; Yalom & Leszcz, 2005).

Key Components of Clinical Supervision

Clinical supervision is one of the strongest coping strategies for preventing compassion fatigue and burnout in workers (Anderson, 2000; Lietz, 2018; Sprang et al., 2011). Within supervision, there are three primary responsibilities: first, to provide support to supervisees, second to provide mentorship/education and third, for administrative functions (Berger and Quiros, 2014; Joubert, Hocking and Hampson, 2013; Kim and Lee, 2009; Lietz, 2018; Merriman, 2015; Strickler et al., 2018).

The ability for the supervisor to accomplish any of the aforementioned goals hinges on the strength of the supervisory working alliance (Kim & Lee, 2009; Sprang et al., 2011; Strickler et al., 2018; Tsong & Goodyear, 2014; Williams et al., 2012). The supervisory working alliance is such an integral component of clinical supervision that it will be explored at length later in the paper.

Support. Support for clinical supervision is broader than the interaction between supervisor and supervisee and includes the organizational climate/workplace culture (Joubert et al., 2013; Kim & Lee, 2009; Mandell et al., 2012). With respect to clinical supervision, Kim & Lee, 2009 state that "human-service managers should focus on developing organizational support, not only support for frontline social workers, but also for supervisors because their skills and relationships with frontline workers are critical assets and resources for the organization" (p. 381).

When the organization is supportive of clinical supervision, it sets the tone for supervisors to take the time to implement regular supervision with workers. As part of providing a safe, structured and supportive framework for supervision, the supervisor and supervisee

openly discuss arranging regular supervision times as well as the limits to confidentiality (Cheon, Blumer, Shih, Murphy, & Sato, 2009; Gnilka, Chang & Dew, 2012; Perry, 2014). It is important to ensure that the supervision space is confidential, and that the supervisor remains uninterrupted during times of scheduled supervision (supervisor not checking emails, answering the telephone, etc.). Communication is collaborative and should include information and feedback from both the supervisor to the supervisee and vice versa. The supervisory working alliance is strengthened when the supervisor is not only open to feedback but also provides feedback in a constructive manner.

Education. Providing supervisees with education and mentorship is another important component of clinical supervision (Berger & Quiros, 2014; Joubert et al., 2013; Merriman, 2015). "The general characteristics of social work amplify the importance of the supervisor's role as a teacher or instructor for frontline social workers" (Kim & Lee, 2009, p. 367). Education starts with clear communication regarding the role of supervision and includes the supervisor and supervisee working together to identify supervision goals. Goals of supervision should be mutually agreed upon and the supervisor should ensure that they are working with the supervisee to track goal progress from session to session (Borders, 2014). Clear communication regarding roles, expectations, boundaries, goals and parameters of supervision assists in reducing role ambiguity for workers. Reduced ambiguity has been identified as another protective factor against compassion fatigue (Lietz, 2018; Sprang et al., 2011; Strickler et al., 2018). As previously stated, clinical supervision is also a time to introduce concepts such as compassion fatigue and countertransference. The educational function includes the supervisor discussing organizational best practices, ethical standards as well as the supervisor taking time to teach the

importance of consulting, debriefing, the use of peer support and appropriate boundaries (Lietz, 2018; Mandell et al., 2012; Mena & Bailey, 2007; Merriman, 2015; Strickler et al., 2018).

Administration. Oftentimes, the administrative function is primarily what supervision ends up being about, leaving very little time to fulfill the other components (Berger & Quiros, 2014; Kim & Lee, 2009; Lietz, 2018). Crisis driven services require emergency consults and timely decision making which is sometimes the extent of the supervision that is provided. New supervisors, in particular, are known to focus more on administrative tasks; this can be due, in part, to their own lack of clinical supervision when they were on the front line (Lietz, 2018). This ties back to the need for the organization to support a culture of clinical supervision within the organization.

There needs to be support and recognition that taking time beyond the administrative functions of supervision is highly valuable. Clinical supervision that incorporates administrative, education/mentoring, and support facilitates deeper dialogue about issues, enhancing critical thinking in workers as well as uncovering triggers and identifying bias (Lietz, 2018).

Supervisory Working Alliance

Much like the therapeutic relationship between counselor and client is considered to be one of the most important vehicles for change, so too is the relationship between supervisor and supervisee (Berger & Quiros, 2014; Kim & Lee, 2009; Lietz, 2018; Strickler et al., 2018; Tsong & Goodyear, 2014). When the supervisory relationship is strong, workers are more willing to adhere to best practices (Sprang et al., 2011; Strickler et al., 2018; Tsong & Goodyear, 2014). However, a poor supervisor/supervisee relationship not only provides barriers to enhanced ethical practice, it can directly impact the client's experience (Gnilka et al., 2012; Lietz, 2018;

Strickler et al., 2018; Tsong & Goodyear, 2014). “It is the quality of the supervisory relationship which tempers the effectiveness of supervision…when supervision fails to be supportive, results can include low morale, job dissatisfaction and high turnover” (Williams et al., 2012, p. 55). Components that support the supervisory working alliance include collaboration, communication, and role modelling (Cheon et al., 2009; Kim & Lee, 2009; Merriman, 2015; Perry, 2014; Strickler et al., 2018; Williams et al., 2012).

It is the role of the supervisor to be a role model for supervisees. This includes their professional conduct as well as their communication style. The supervisor role models transparency throughout the clinical supervision process, openly discussing expectations, limitations and seeks input from the supervisee about their supervision needs (Cheon et al., 2009; Gnilka et al., 2012; Perry, 2014).

It is relevant for the supervisor to acknowledge and openly discuss the power imbalance within the relationship, modelling integrity and fostering trust within the supervisory working alliance. The power imbalance between supervisor/supervisee becomes all too apparent when evaluations need to occur (Cheon et al., 2009). The process of formal evaluation can, in itself, strain the supervisory working alliance (Cheon et al., 2009). It is imperative that when formal evaluations do occur, the supervisor is transparent about what is going to be reported and provides feedback to the supervisee that is direct, honest and constructive (Merriman, 2015).

Another fundamental part of role modelling is how the supervisor conducts themselves outside of supervision settings (Williams et al., 2012). When a supervisor can conduct themselves in an ethical manner and role model expectations that they have of their subordinates, the supervisory working alliance can be further enhanced (Williams et al., 2012). Supervisors should strive to acknowledge their own limits of competence, seek their own supervision, show

that they value ongoing learning and self-reflection and model self care and appropriate self-disclosure if they want to be able to ask the same of their supervisees (Borders, 2014; Williams et al., 2012). These components tie back in to the need for good communication; both verbally and non-verbally. If the supervisor can "walk the talk" then they are conducting themselves authentically which assists in building the supervisory working alliance (Borders, 2014).

Sterner states: "supervisor characteristics typically associated with a positive supervisory working alliance were being non-judgemental, providing validation, supporting exploration, imparting an empathic attitude, normalizing anxiety and tension…" (p. 250). When supervisors can create an environment of safety for supervisees, ethical practice can more easily occur. The safety that is created allows supervisees to be honest about the challenges they are facing in practice. Safety in the supervision relationship means that supervisees do not need to edit their true experiences out of concern for how the supervisor may react/think (Barnett & Molzon, 2014; Kim & Lee, 2009; Perry, 2014; Sprang et al., 2011; Sterner, 2009; Strickler et al., 2018). If a good supervisory working alliance can be established, supervisees will experience support and growth as professionals, reducing the impacts of work-related stress that can lead to compassion fatigue.

A strong supervisory working alliance does not mean that there cannot be disagreement between supervisor/supervisee. In fact, conflict can be an opportunity for further growth and strengthening of the supervisory working alliance- provided that the conflict is managed in an ethical manner (Cheon et al., 2009). When conflict emerges, how it is addressed enables the supervisor and supervisee to learn more about each other's learning and communication styles. It also enhances feelings of safety and support for workers who experience conflict and have supervisors who manage the conflict in ethical and appropriate ways (Cheon et al., 2009).

"Social workers who enjoy open communication relationships with supervisors will be more likely to perceive their supervisory relationships as participatory and trustworthy" (Kim & Lee, 2009, p.368).

Supervisor Skills/Supervisor Competence

The supervisor's personality type does not mean that a supervisor cannot work with a wide range of supervisee personality types (Cheon et al., 2009; Mena & Bailey, 2007). It has been established that there are several supervisor competencies that enhance supervisor success. Supervisors who are able to tolerate stress, actively encourage boundaries between clients and workers, and encourage workers to not only have work/life balance but to seek support when they are struggling, possess the attributes necessary to build a strong supervisory working alliance and positive supervision experience (Perry, 2014; Mandell et al., 2012; Williams et al., 2012). Challenges occur more often when the organization does not have a "culture" of clinical supervision, or when supervisors are not comfortable with supervision beyond administrative functions (Lietz, 2018).

It is encouraged that new supervisors receive formal training to understand all of the functions of clinical supervision and how to conduct supervision. After training, it is vital that new supervisors receive ongoing organizational support to implement supervision (Goodyear et al., 2014; Lietz, 2018). According to Borders: "Competencies outline required declarative knowledge, or what a competent supervisor needs to know; best practices provide the basis for procedural knowledge, describe when and how declarative knowledge is applied, or what a supervisor does during supervision. …supervision competencies and best practices should not take an either/or perspective…" (2014, p. 152).

Client Outcomes

All components of clinical supervision, especially the supervisory working alliance impact client outcomes. “When caseworkers are not able to engage in in-depth case reviews with their supervisor, the safety and well-being of children can also be impacted…” (Lietz, 2018, p. 332). This is accomplished through a parallel process (Jacobesen, 2007; Lietz, 2018; Strickler et al., 2018). The parallel process is the process of supervisor’s role modelling appropriate interactions with supervisees, which, in turn, impacts how supervisees work with clients. The supervisory working alliance assists in monitoring and supporting supervisee well-being, and supervisee well-being directly impacts the service that clients receive (Cheon et al., 2009; Gnilka et al., 2012; Lietz, 2018; Mena & Bailey, 2007).

Summary of Chapter Two

It is acknowledged that human services work is challenging and that as a result, workers are at increased risk of experiencing negative consequences such as compassion fatigue. Fortunately, there are a range of protective factors that can be implemented to guard against these effects.

The literature has identified clinical supervision as an essential component for monitoring and supporting workers to guard against compassion fatigue. Clinical supervision requires organizational support as well as supervisory competency in order to be fully effective. It also must go beyond administrative functions to include supervisee support as well as mentoring and education. The long-term advantages of taking the time to conduct regular clinical supervision in a fulsome way, is that workers remain in the field and are healthy (emotionally, physically and psychologically). This was not explored in the literature review however; it is not a stretch to

deduce that workers who are functioning healthily will remain in their chosen field longer, will most likely take fewer sick days and will provide better service to clients.

Chapter Three: Project Plan

Introduction

The attached project is a guidebook for clinical supervision. The guidebook has been informed by a thematic literature review on the topic of clinical supervision. The themes that emerged during the review were not only around clinical supervision as a process, but also how it serves as a protective factor for workers against compassion fatigue and countertransference issues. The theme that emerged as an over-encompassing theme, throughout all aspects of clinical supervision, was the supervisory working alliance.

As a result, the guidebook includes an introduction to the topic of clinical supervision as well as context for why clinical supervision is vital to maintaining worker health and well-being. It draws attention to the supervisory working alliance, asserting its significance for successful supervision and breaks down the components of effective supervision, providing basic information and guidance to help inform supervisor's practice. Refer to chapter four for the complete guidebook.

It is worth noting that similar to counselling, clinical supervision has a variety of theoretical models; most generally fall under one of three broader categories: psychotherapy, developmental and process (Bernard & Goodyear, 2014). Supervisors oftentimes use an integrative approach that borrow from several theoretical models. This project intentionally did not delve into defining and exploring the range of theoretical models for two primary reasons. The first being that it would shift the project focus to a very academic review of theoretical constructs. While theories are important to know and locate oneself within, as discussed in chapters one and two, there is already enough confusion regarding what the primary concept of clinical supervision is and why it is necessary. The second reason for excluding the theoretical

models is that this project's focus is to make it user friendly and meaningful for supervisors with a range of experience to easily implement new tools to enhance their practice. Again, theoretical location is recognized as highly important, I would suggest that the attached guidebook be used as a start and then encourage supervisors to further explore their theoretical orientation once they feel comfortable with executing the basic fundamentals of clinical supervision. This would further elevate their clinical supervision abilities.

Description of Project

As previously stated, this guidebook is the result of a thematic literature review on the topic of clinical supervision. When initially conducting research on clinical supervision, the functions of clinical supervision-support, education/mentoring, and administration-clearly emerged. However, as a review of the literature continued, the concept of compassion fatigue appeared as a consequence of lack of clinical supervision.

The guidebook starts with a very brief overview of what readers can expect. The intent of the overview is to acknowledge that the guidebook is proposing to enhance current supervisory practice, not for supervisors to start anew.

The guidebook then moves on to discuss the value of clinical supervision. This section validates the workplace stress and difficulty within the human services field. The literature identified, and it is clearly stated within this section, that the concept of clinical supervision oftentimes is administrative supervision. This section concedes that (as supported by the literature) the consequences of continuing to conduct administrative supervision alone, as status quo, will continue to result in burnout and worker turnover. It is a challenge for supervisors to

shift their definition of supervision by providing clear rational for the shift, hence this section is called “clinical supervision, shifting workplace landscapes”.

What also emerged from the literature review was evidence that there is ambiguity between the concepts of compassion fatigue and countertransference. What was discovered was that, in the human services field (including social work and health services, not exclusively counseling) there was some confusion surrounding the concepts. This surprised me, being a current student in a counselling program, compassion fatigue and countertransference are very distinct in my mind, however, this was not evident in the literature. As a result, the guidebook includes a glossary of terms section to differentiate and define the terms separately. I chose to also include the term transference in the guidebook to contrast it with countertransference; this was not as a result of anything that the literature specifically highlighted.

The guidebook then moves in to the functions of clinical supervision. The literature clearly identified three separate components- support, mentorship/education and administrative. It distinctly separates these functions, providing a brief definition for each. It then restates that administrative is the function almost exclusively used and therefore does not spend any further time elaborating on that function. What the guidebook does do at this juncture, is expand further on the other two components of clinical supervision. It provides practice examples to emphasize the distinctions and provide supervisors with tangible practices that they can implement immediately.

The supervisory working alliance appeared throughout the literature as the vehicle for clinical supervision to productively occur. This led to an examination of supervisor competencies. Within the guidebook, a large section is dedicated to defining what the supervisory working alliance is and how to establish/strengthen it. The guidebook provides basic

points for supervisors to consider that the literature showed are oftentimes overlooked, again, concrete examples are provided in order to facilitate practice shifts. The intent with providing basic examples is to demonstrate that change can be easier than it may appear at first glance. As stated in the overview section, the goal is to enhance current practice, it is less daunting to add one or two things here and there than it is to start from the beginning. Supervisor competencies essentially boiled down to the supervisor conducting themselves in a congruent manner, supervisors need to be the same people inside of the supervision session as they are in any other setting. This section is a challenge to supervisors to "walk the talk" with respect to boundaries, conduct, and self-care and is why this section is titled "supervisor as the vehicle".

Ethics was not explicitly discussed in the literature that was reviewed. Ethics was mentioned occasionally as a positive result of worker job satisfaction and increased competency, both of which clinical supervision has a large bearing on. Although not fully explored in the literature review, a brief section on ethics has been included in the guidebook because it seemed highly important to be clear that clinical supervision enhances ethical practice.

In summary, the guidebook that follows provides a framework for clinical supervision. It is intended to enhance current supervisory practice by providing context for why supervision is so important and then offering examples to shift the clinical supervision experience.

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CLINICAL SUPERVISION:

COMBATTING ATTRITION IN THE HUMAN SERVICES FIELD

Katherine Marchand, M.Ed.

Table of Contents

Overview

"It is one of the most beautiful compensations of this life that no man can sincerely try to help another without helping himself."

Ralph Waldo Emerson

The purpose of this guidebook is to provide the foundation necessary for supervisors to implement, what may be for some, a different form of supervision practice. This will be accomplished by first providing context for why clinical supervision is such a vital component within the workplace. Next, this guidebook will provide the supervisor with tools to enhance their supervision practice.

This guidebook is not intended to be a rigid, linear supervision model, instead it will provide a framework that supervisors can adjust to fit their own natural styles. Supervisors should use this document as a guideline, incorporating which tools make the most sense to them.

Clinical Supervision, Shifting Workplace Landscapes

Clinical supervision has been highlighted as a fundamental protective factor that can greatly reduce the felt effects of workplace stress in the human services field. It is acknowledged that the nature of the work oftentimes results in supervision being conducted for administrative purposes, leaving worker's unsupported and on their own to manage workload stress. The results can range from worker's emotionally suffering in silence to worker's leaving the field, unable or unwilling to sacrifice themselves for work and uncertain how else to manage the effects of chronic stress.

Clinical supervision, when fully implemented, contains components that facilitate the "unpacking" of worker's challenging experiences. The outcomes are that worker capacity is increased, burnout and turnover are reduced, and ethical practice is strengthened.

Human services work inherently comes with a unique set of occupational hazards. The difficulty is assessing how ongoing exposure is impacting workers.

Clinical supervision provides a platform for ongoing dialogue between the supervisor and supervisee to name and normalize the hazards. This not only assists in buffering the supervisee against the hazards but also has a positive impact on client experience. This will be further elaborated on within the "supervisor as the vehicle" and "ethics" sections.

Glossary of Terms

Let us take a moment to define some of the primary hazards that human services workers face: compassion fatigue, countertransference and transference.

Compassion Fatigue

Compassion fatigue is a term that is often used interchangeably with terms such as vicarious trauma and burnout.

Merriam Webster defines compassion fatigue as: "the physical and mental exhaustion and emotional withdrawal experienced by those who care for sick or traumatized people over an extended period of time."

Compassion fatigue is not an essential component of working with people but is more a consequence of accumulated, unaddressed thoughts and feelings surrounding the work. Worker's "who experience compassion fatigue absorb the emotional weight of their clients' traumatic experiences in ways that negatively impact both their professional identities and personal lives" (Berzoff & Kita, 2010, p.342).

Compassion fatigue is cumulative; fortunately, there are several protective factors that can reduce the risk of compassion fatigue to workers.

It is not uncommon for workers to experience any of the indicators listed below occasionally. However, when signs are ongoing and intrusive (personally and professionally), that is a clear indication that workers are experiencing compassion fatigue.

The chart below provides a list of indicators of distress that supervisors can use to assist in determining whether a supervisee may be experiencing some level of compassion fatigue. The chart is not exhaustive but provides some things to consider when assessing worker distress.

Individual Indicators of Distress	
Emotional Indicators Anger Sadness Prolonged Grief Anxiety Depression	**Physical Indicators** Headaches Stomach Aches Lethargy Constipation
Personal Indicators Self-Isolation Cynicism Mood Swings Irritability with Spouse/Family	**Workplace Indicators** Avoidance of Certain Clients Missed Appointments Tardiness Lack of Motivation

-Table from Perry, 2014 p. 14

As previously stated, there are protective factors against compassion fatigue that organizations, supervisors and workers can utilize; clinical supervision is the common thread.

Organization:

- Encourages peer debriefing/supervision
- Supports time for **clinical supervision**
- Promotes work/life balance

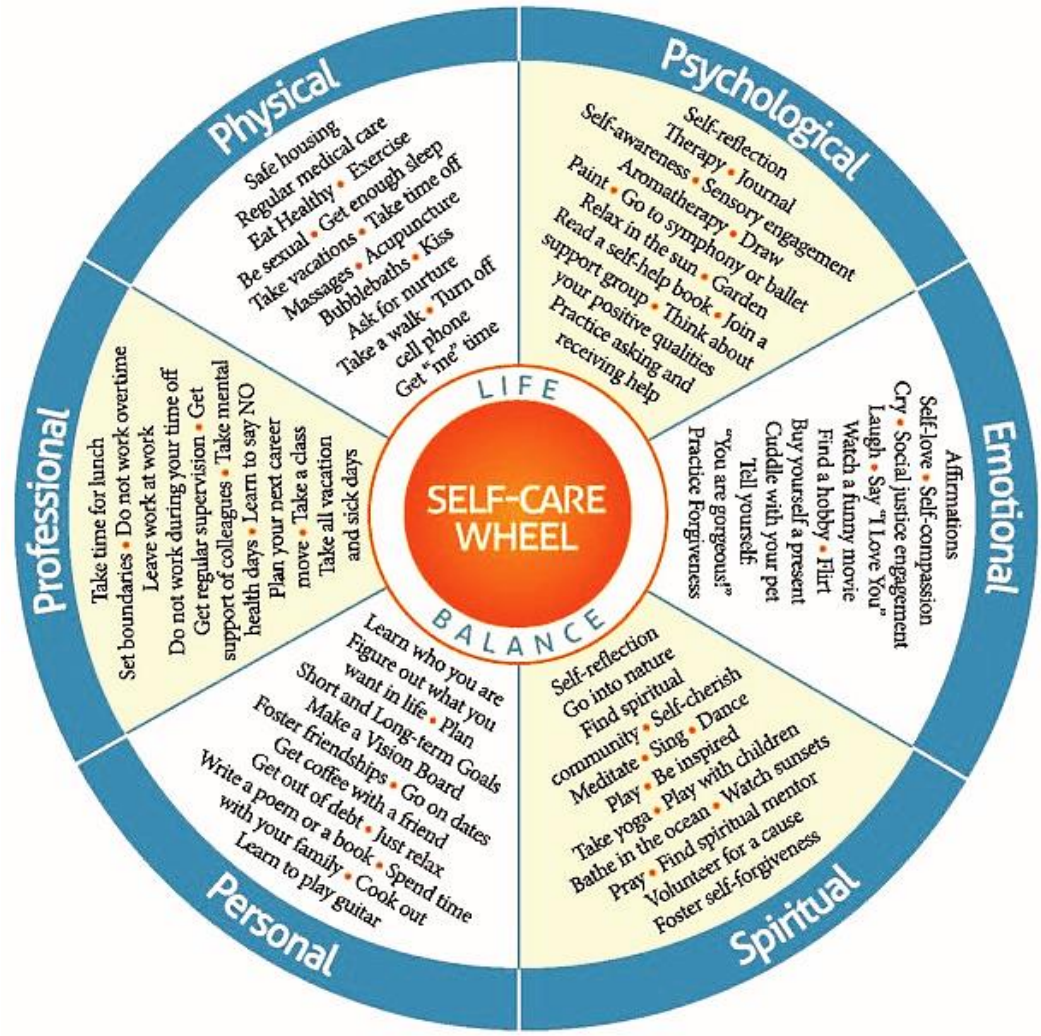
Clinical Supervision:

- Define compassion fatigue
- Discuss risks and protective factors
- Define self-care and its value
- Normalize supervisee feelings/experiences
- Assist in combatting professional isolation
- Supervisor role-models appropriate self-care
- Supervisor role-models appropriate boundary setting

Worker:

- **Clinical supervision**
- Self-care

Workers actively engage in self-care as a means to combat compassion fatigue. The chart below, from www.OlgaPhoenix.com, provides a range of suggestions for self-care practice.

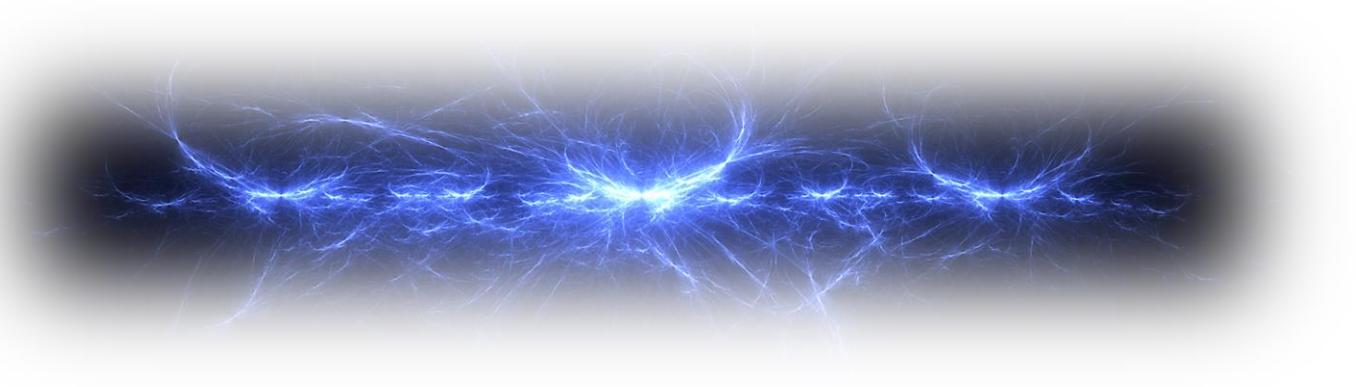


Countertransference

Gerald Corey broadly defines countertransference as "…any of our projections that influence the way we perceive and react to a client. This phenomenon occurs when we are triggered into emotional reactivity, when we respond defensively, or when we lose our ability to be present in a relationship because our own issues become involved" (Corey, 2013, p.31).

It is worth noting that countertransference does not only occur from worker to client but can also occur from worker to supervisor or vice-versa. This makes it even more integral to ensure that supervisors/supervisees are not only aware of the concept but also that there is active work by both parties to address it when they experience it.

Compassion fatigue and countertransference are two distinct phenomenon's that oftentimes emerge when working within human services. Compassion fatigue can be guarded against whereas countertransference is expected to occur and needs to be acknowledged and worked through each time it emerges.



There are a variety of signs that indicate that countertransference is occurring or at risk of occurring. Some of those signs are:

- Having intense feelings (e.g. irritation, anger, boredom, sexual attraction) for clients you hardly know
- Feeling attraction or repulsion
- Being reluctant to confront or tending to avoid sensitive issues or feelings
- Continually running overtime with certain clients and wishing others would not show up for scheduled appointments
- Acting with rescuing behavior, such as wanting to lend money, adopt abused children or protect clients
- Being reminded by clients of other people you know
- Dealing with clients who have similar problems or personal histories
- Employing unnecessary or excessive self-disclosure
- Feeling reluctant to end the counselling relationship

Shebib, 2003, p.84

Transference

"A hurtful act is the transference to others of the degradation which we bear in ourselves"
-Simone Weil

Transference is similar to countertransference in that it is a transfer/projection of feelings and reactions from one person to another. Unlike countertransference, where you are reacting to another person, transference is the other person's reactions to you. Corey defines transference as "the client's unconscious shifting to the analyst of feelings and fantasies that are reactions to significant other in the client's past. …Transference takes place when clients resurrect from their early years intense conflicts relating to love, sexuality, hostility, anxiety, and resentment; bring them to the present; reexperience them; and then attach them to the therapist" (Corey, 2013, p.75).

Functions of Clinical Supervision

In their 2018 article: "Infusing clinical supervision throughout child welfare practice: Advancing effective implementation of family-centered practice through supervisory process" Lietz identified three fundamental functions of clinical supervision: support, education, and task (administrative).

Support to the Supervisee

Includes a workplace culture that supports time for supervision, recognizing that workers are critical assets within the organization.

Mentorship and Education

Not only discussing organizational roles and best practices but also discussing concepts such as compassion fatigue and countertransference.

Administrative

Administrative functions include case consultations as well as file assignments and day to day schedule of work tasks.

"The quality of supervision has implications for workforce development as it impacts job satisfaction and retention of workers which has an indirect effect on client outcomes."

-Lietz, 2018, p.333

While there are three clear functions that clinical supervision serves, generally, supervision tends to focus, almost wholly, on administrative functions. This occurs due to the nature of the work being crisis driven, requiring timely decision making.

Given administrative function is the most frequent experience workers will have with supervision, time will be spent exploring the other two functions.

"Human-service managers should focus on developing organizational support, not only for frontline social workers, but also for supervisors because their skills and relationships with frontline workers are critical assets and resources for the organization" (Kim & Lee, 2009, p. 381).

Support to the Supervisee

Human services work is challenging, demanding workers to continually do more with less. It is essential for supervisees to have support. The organizational culture is integral to providing a foundation for supporting workers at all levels. An organizational culture that recognizes the value of clinical supervision as one of the protective factors against compassion fatigue is critical.

What are some things that organizations can do to create a culture that embraces clinical supervision?

- Role-model clinical supervision up the organization's management chain
- Provide permission for supervisors to create the time and space in their schedules to conduct clinical supervision
- Structure time for supervision that includes not only administrative components but also education and rapport/relationship building
- Encourage critical thinking that includes not only supervisors challenging workers but also workers challenging supervisors with the goal being to enhance practice
- Create an organizational structure that is collaborative versus "top down"

Mentorship and Education

Mentorship and education, on the surface, are basic practices that should be reasonably easy for supervisors to implement in their supervision practice. The reality though, is that this function can easily be confused with administrative functions, depending on the delivery of the information. There is a fine line between providing information to direct practice (administrative supervision) and engaging in critical discussions where all parties involved have similar power to contribute (mentoring supervision). It is important to integrate administrative, and mentorship/education in supervision practice.

How can supervisors enhance their mentorship and education functions through clinical supervision?

- Clear communication about the role of supervision, including consideration of a supervision contract to concretely define roles and structure sessions (reduces role ambiguity)
- Provide time/space to openly discuss concepts such as compassion fatigue, countertransference and transference, include some personal disclosure about your own experiences, successes as well as challenges (normalizing)
- Role model what you are asking your supervisee to do (walk the talk)

Supervisor as the Vehicle

Clinical supervision is essential to support workers to remain in the human services field. It normalizes workers experiences and provides support to ensure retention. Clinical supervision relies on the supervisory working alliance for optimal results. Essentially, having the supervisor themselves as the vehicle for successful practice.

Leaders must either invest a reasonable amount of time attending to fears and feelings, or squander an unreasonable amount of time trying to manage ineffective and unproductive behavior…we also have to invest time attending to our own fears, feelings, and history or we'll find ourselves managing our own unproductive behaviors. As daring leaders, we have to stay curious about our own blind spots and how to pull those issues into view, and we need to commit to helping the people we serve find their blind spots in a way that's safe and supportive.

-Brene Brown, 2018, p.113

The supervisory working alliance is strengthened through providing an atmosphere of collaboration, trust, empowerment and role-modelling. The relationship takes time and focused effort to grow stronger.

As previously stated, providing a structured framework for clinical supervision reduces role ambiguity and sets the stage for the supervision experience. The framework for supervision should be a collaborative endeavor between supervisor and supervisee. Things that should be considered when discussing the framework are:

- Consistent supervision times
- Defining confidentiality within the supervision process, including limits to confidentiality
- Goals for supervision (goals should not only be administrative)
- Acknowledging and discussing the power differential between supervisor and supervisee

Identifying a framework for clinical supervision is a first step in building trust and a collaborative relationship. It is important that whatever the agreed upon structure of the supervision session, the supervisor makes reasonable efforts to adhere to it.

It is also vital that wherever the supervision sessions occur (as agreed upon), the supervisor creates an atmosphere of trust and safety for the supervisee. Some ways this can be accomplished:

- Supervisor limits distraction and focuses on task at hand (i.e. does not answer phone calls, check emails, etc.)
- Supervisor models appropriate self-disclosure
- Supervisor is transparent about their own strengths and limitations and what they are doing to address them
- Supervisor invites feedback and honest discussion
- Each session is structured in a predictable way that the supervisor follows

"To be persuasive we must be believable; to be believable we must be credible; to be credible we must be truthful."

Edward R. Murrow

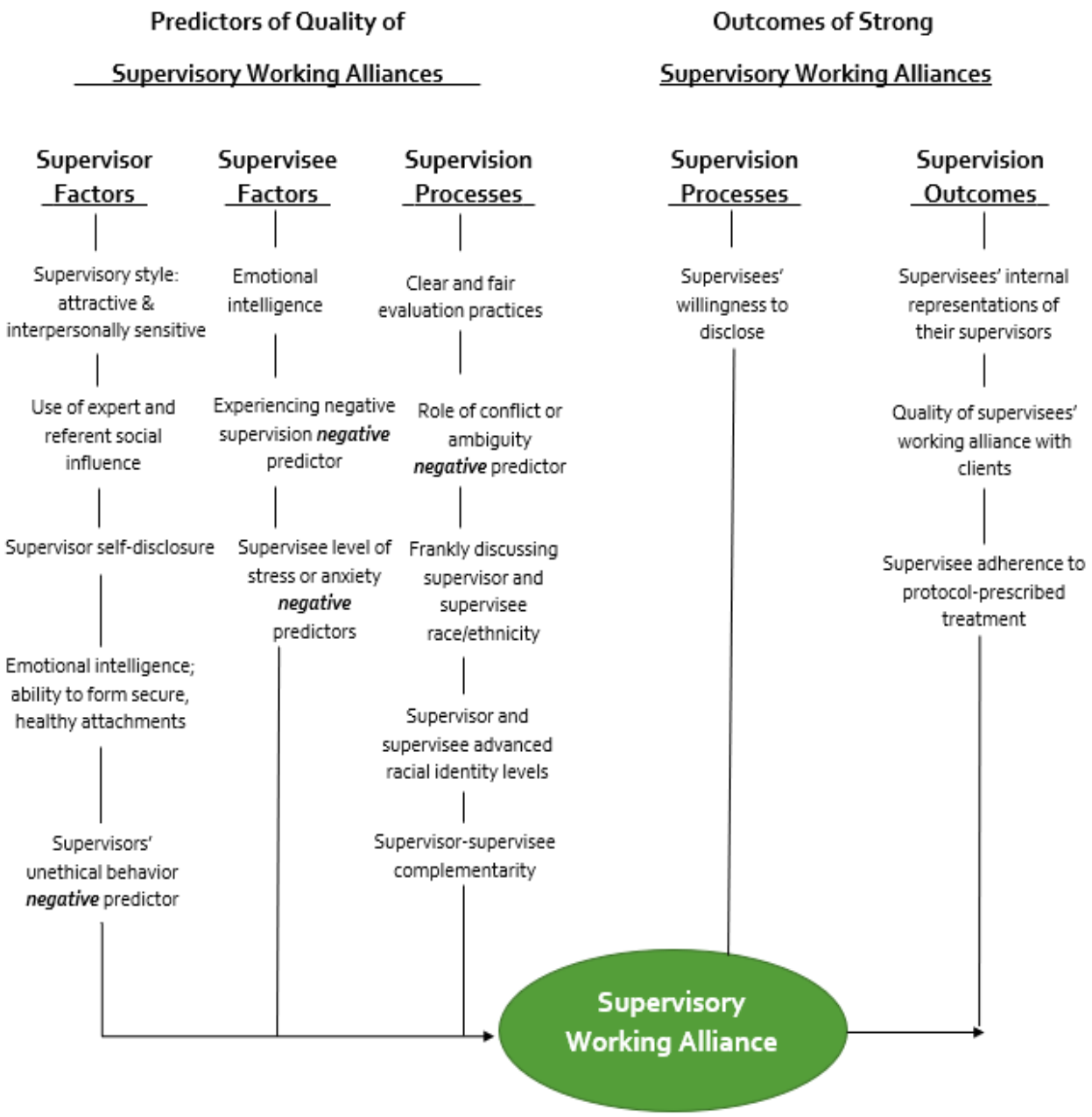
It is critical that the supervisor is able to role-model professional, ethical and compassionate conduct outside of the clinical supervision session. This fosters trust and shows integrity.

That means, maintaining confidentiality, practicing self-care and setting boundaries with the organization, colleagues and clients. It also means knowing when to admit that you don't have all of the answers but can commit to journeying together with the supervisee to learn. It is a commitment to ongoing personal and professional development and sharing that journey with others.

The diagram on the following page summarizes the key factors that contribute to a strong supervisory working alliance. It identifies supervisor and supervisee factors that predict the quality of the working alliance. It notes not only positive predictors but also negative factors. A supervisor may choose any one of the predictors to work on strengthening.

The chart can be used to assist in planning how to conduct supervision and may also be a tool to assist the supervisor in having an initial supervision conversation with a supervisee.

The supervision outcomes identified are likely what most supervisors want to achieve in supervision practice. The diagram charts a clear course to achieve positive outcomes.



From Bernard & Goodyear, 2014, p. 73

Ethics

"I alone cannot change the world, but I can cast a stone across the water to create many ripples."

Mother Teresa

Clinical supervision is the means by which ethical practice is assured. The supervisor and supervisee collaborate to define the risk factors associated with human services work. They then work together to implement protective factors, all through using a strong supervisory working alliance.

The British Columbia College of Social Workers (BCCSW) code of ethics states, among other things, that:

- A social worker shall maintain the best interest of the client as the primary professional obligation
- A social worker shall carry out professional duties and obligations with integrity and objectivity
- A social worker shall have and maintain competence in the provision of social work services to a client

Supervisors and supervisees establish an atmosphere of trust that enables recognition and support for any circumstance. The result of strong, consistent clinical supervision is better client experiences.

Within the context of a safe supervisory atmosphere, workers are encouraged to work on recognizing countertransference. Once identified, workers are then able to separate their reactions from the client, enhancing objectivity.

Workers gain skills through the supervision process that they can apply to their direct work with clients. This is referred to as a parallel process. Parallel process occurs when the worker is role-modelled appropriate interactions, boundary setting, and self-disclosure, they, in turn, model those behaviors towards clients. The growth and learning that can be facilitated through this process increases worker competence, which positively impacts client experiences.

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